POC accepted 4/29/10 B. Cwenar RFSW

PRINTED: 04/09/2010
FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN1218SNF	A. BUILDING _____ B. WING _____	03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE PINE CARE CENTER	1500 AVENUE G ELY, NV 89301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation initiated off site on 3/23/10 and finalized in your facility on 3/31/10, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. Complaint #NV00024857 was substantiated with a deficiency cited. (See Tag Z140). Complaint #NV00022069 was unsubstantiated. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000	**White Pine Care Center, Ely NV Plan of Correction for Complaint Survey of 3/31/10.** **Z310 SS=D** **NAC449.74493 Notification of Changes or Condition** **Corrective Action Taken:** Family member and resident met with physician and charge nurse to discuss wound care, changes, treatment options, potential issues affecting healing and to develop a plan of care. **Other Residents Potentially Affected:** Residents potentially affect are residents who: has been injured in an accident and may require treatment from a physician, residents who have had a deterioration in mental, physical or psychosocial health resulting in medical complications or a threat to that residents life. Discontinuation of treatment due to adverse affects or to begin a new treatment. Transfer or discharge. Room change or new roommate. Any change in federal or state law that would affect the rights of the resident.	
Z310 SS=D	NAC449.74493 Notification of Changes or Condition 1. A facility for skilled nursing shall immediately notify a patient, the patient's legal representative or an interested member of the patient's family, if known, and, if appropriate, the patient's physician, when: (a) The patient has been injured in an accident and may require treatment from a physician;	Z310		

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

June C. Madusla — TITLE: Executive Director — (X6) DATE: 4/15/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

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Z310	Continued From page 1 (b) The patient's physical, mental or psychosocial health has deteriorated and resulted in medical complications or is threatening the patient's life; (c) There is a need to discontinue the current treatment of the patient because of adverse consequences caused by that treatment or to commence a new type of treatment; (d) The patient will be transferred or discharged from the facility; (e) The patient will be assigned to another room or assigned a new roommate; or (f) There is any change in federal or state law that affects the rights of the patient. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to notify the resident's family of a change in condition that required a change of the treatment plan for Resident #1. Severity: 2 Scope: 1 	Z310	**Measures to prevent reoccurrence:** Nursing staff will be inserviced by: Executive Director explanation and training at all-staff 4/23/10. Memo notification to all nurses 4/15/10. Re-education and notification to be read, signed and returned by all nurses and accompanying payroll checks 4/24/10. Copy of BHCQ&C findings and POC to be provided to all nursing staff to review. **Measures to monitor program effectiveness:** All changes documented on 24 hour report, reviewed by DNS and reviewed by IDT at Stand up meeting (M-F). DNS or Designee will monitor to ensure documentation of notification of family members/responsible party is in resident chart. **The responsible party for monitoring and accomplishing compliance** will be the Director of Nursing Services or designee. **Anticipated Date of Correction: 4/24/10**	